Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Montana HCS (VAM&ROC Ft. Harrison - 436 and VA Eastern Montana HCS - 436A4), Miles City, MT

VISN 19

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 290

2. Point-in-time estimate of Veterans who are Chronically Homeless: 58

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **290** (point-in-time estimate of homeless veterans in service area) **X 23%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 58** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	49	0
Transitional Housing Beds	22	20
Permanent Housing Beds	21	70

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Work with Montana groups to find more permanent housing. Encourage shelter providers to outreach for more permanent housing. Watch for NOFAs for permanent housing.
Dental Care	Hopefully, increase dental care by keeping veterans in program for 60+ days and helping them keep their dental appointments. Refer to community dental services.
Glasses	Hopefully, increase eye glass provision by community organizations.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 61 Non-VA staff Participants: 77% Homeless/Formerly Homeless: 11%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.68	33%	2.25	1
2	Drop-in center or day program	2.19	7%	2.77	10
3	Child care	2.23	0%	2.39	3
4	Glasses	2.29	5%	2.67	6
5	Dental care	2.31	9%	2.34	2
6	Eye care	2.32	6%	2.65	5
7	Legal assistance	2.38	2%	2.61	4
8	Halfway house or transitional living facility	2.53	19%	2.76	8
9	Job training	2.59	4%	2.88	14
10	Education	2.68	4%	2.88	13
11	Help managing money	2.84	0%	2.71	7
12	Discharge upgrade	2.84	2%	2.90	15
13	Family counseling	2.85	2%	2.85	12
14	Treatment for dual diagnosis	2.89	6%	3.01	18
15	Help with finding a job or getting employment	2.89	9%	3.00	17
16	Welfare payments	2.94	0%	2.97	16
17	Detoxification from substances	3	9%	3.11	22
18	Help getting needed documents or identification	3	0%	3.16	23
19	Women's health care	3.04	0%	3.09	21
20	Treatment for substance abuse	3.05	17%	3.30	28
21	SSI/SSD process	3.06	0%	3.02	19
22	Personal hygiene (shower, haircut, etc.)	3.07	4%	3.21	26
23	Services for emotional or psychiatric problems	3.07	9%	3.20	25
24	Guardianship (financial)	3.08	0%	2.76	9
25	Help with medication	3.18	7%	3.18	24
26	TB treatment	3.21	0%	3.45	33
27	AIDS/HIV testing/counseling	3.24	0%	3.38	30
28	Help with transportation	3.25	0%	2.82	11
29	VA disability/pension	3.31	4%	3.33	29
30	Clothing	3.34	6%	3.40	31
31	Spiritual	3.37	9%	3.30	27
32	TB testing	3.38	0%	3.58	36
33	Emergency (immediate) shelter	3.4	19%	3.04	20
34	Hepatitis C testing	3.48	0%	3.41	32
35	Medical services	3.61	6%	3.55	34
36	Food	3.75	6%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.47	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.07	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.91	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.98	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.72	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.79	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.54	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.64	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.54	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.16	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.51	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.78	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.75	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.96	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.08	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.76	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.7	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.76	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.75	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAM&ROC Cheyenne, WY - 442

VISN 19

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Point-in-time estimate of Veterans who are Chronically Homeless: 21

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **50** (point-in-time estimate of homeless veterans in service area) **X 46%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 91%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 21** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	10
Transitional Housing Beds	75	10
Permanent Housing Beds	20	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Complete building of 12 permanent housing units. Support coalition members in grant applications for additional permanent housing and Section 8 grants.
Help with finding a job or getting employment	Wyoming Rural Development Council is hiring a "Main Street" coordinator for state of Wyoming. Economic development is a major focus of many state board and commissions. The business-ready communities program is growing.
Job Training	While referring all eligible veterans to VA vocational rehabilitation, our Healthcare for Homeless Veterans program is working with Wyoming DVR and local agencies who are providing job readiness classes and job training programs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 46 Non-VA staff Participants: 84%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.46	23%	2.25	1
2	Legal assistance	2.6	3%	2.61	4
3	Child care	2.78	3%	2.39	3
4	Drop-in center or day program	2.85	0%	2.77	10
5	Eye care	2.85	6%	2.65	5
6	Glasses	2.85	3%	2.67	6
7	Family counseling	2.88	3%	2.85	12
8	Help managing money	2.88	3%	2.71	7
9	Help with transportation	2.88	3%	2.82	11
10	Guardianship (financial)	2.9	0%	2.76	9
11	Treatment for dual diagnosis	2.91	0%	3.01	18
12	Welfare payments	2.97	0%	2.97	16
13	Halfway house or transitional living facility	3	10%	2.76	8
14	SSI/SSD process	3	0%	3.02	19
15	Education	3.06	3%	2.88	13
16	Treatment for substance abuse	3.09	13%	3.30	28
17	Dental care	3.09	13%	2.34	2
18	TB treatment	3.13	0%	3.45	33
19	Job training	3.15	28%	2.88	14
20	AIDS/HIV testing/counseling	3.16	3%	3.38	30
21	TB testing	3.16	0%	3.58	36
22	Hepatitis C testing	3.16	3%	3.41	32
23	Detoxification from substances	3.18	6%	3.11	22
24	Services for emotional or psychiatric problems	3.24	3%	3.20	25
25	Women's health care	3.24	0%	3.09	21
26	Help with finding a job or getting employment	3.24	23%	3.00	17
27	Discharge upgrade	3.24	0%	2.90	15
28	Help getting needed documents or identification	3.28	3%	3.16	23
29	Personal hygiene (shower, haircut, etc.)	3.31	3%	3.21	26
30	Help with medication	3.38	6%	3.18	24
31	Medical services	3.39	19%	3.55	34
32	VA disability/pension	3.48	6%	3.33	29
33	Emergency (immediate) shelter	3.51	3%	3.04	20
34	Food	3.56	0%	3.56	35
35	Spiritual	3.57	0%	3.30	27
36	Clothing	3.64	0%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.73	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.63	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.08	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.05	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.86	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.88	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.83	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.65	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.69	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.13	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.28	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.34	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.3	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.96	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.32	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.26	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.26	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.43	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Denver, CO - 554

VISN 19

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1193

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3500** (point-in-time estimate of homeless veterans in service area) **X 41%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 83%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1193** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	991	164
Transitional Housing Beds	657	80
Permanent Housing Beds	148	185

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Provide input to Interagency Council on Homelessness regarding permanent housing for homeless veterans. Provide input into 10-year planning process to end chronic homelessness (all localities).
Dental Care	Work with VA leadership to implement Dental Directive for homeless veterans in residential programs.
Transitional living facility	Identify grant opportunities through VA and the Continuum of Care SuperNOFA process.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 61 Non-VA staff Participants: 83%
Homeless/Formerly Homeless: 15%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.78	35%	2.25	1
2	Child care	2.08	4%	2.39	3
3	Dental care	2.11	11%	2.34	2
4	Drop-in center or day program	2.23	2%	2.77	10
5	Halfway house or transitional living facility	2.24	26%	2.76	8
6	Legal assistance	2.33	0%	2.61	4
7	Emergency (immediate) shelter	2.47	37%	3.04	20
8	Education	2.47	0%	2.88	13
9	Job training	2.54	5%	2.88	14
10	Eye care	2.55	4%	2.65	5
11	Glasses	2.57	2%	2.67	6
12	Help with finding a job or getting employment	2.61	11%	3.00	17
13	Treatment for dual diagnosis	2.65	5%	3.01	18
14	Help with transportation	2.67	2%	2.82	11
15	Family counseling	2.68	0%	2.85	12
16	Welfare payments	2.72	0%	2.97	16
17	Discharge upgrade	2.76	0%	2.90	15
18	Guardianship (financial)	2.77	0%	2.76	9
19	Treatment for substance abuse	2.79	9%	3.30	28
20	Women's health care	2.8	0%	3.09	21
21	Help managing money	2.8	0%	2.71	7
22	Help getting needed documents or identification	2.8	2%	3.16	23
23	Detoxification from substances	2.82	7%	3.11	22
24	Services for emotional or psychiatric problems	2.84	7%	3.20	25
25	Help with medication	2.93	5%	3.18	24
26	SSI/SSD process	2.93	2%	3.02	19
27	Personal hygiene (shower, haircut, etc.)	3.02	2%	3.21	26
28	AIDS/HIV testing/counseling	3.09	0%	3.38	30
29	TB treatment	3.19	0%	3.45	33
30	Spiritual	3.19	4%	3.30	27
31	VA disability/pension	3.28	0%	3.33	29
32	Clothing	3.34	5%	3.40	31
33	Medical services	3.34	7%	3.55	34
34	Hepatitis C testing	3.35	0%	3.41	32
35	TB testing	3.46	0%	3.58	36
36	Food	3.49	9%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.36	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.12	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.68	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.79	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.51	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.32	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.32	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.46	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.93	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.75	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.86	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.56	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.56	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.98	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.58	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.7	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.79	1.84

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CHALENG 2004 Survey: VAMC Grand Junction, CO - 575

VISN 19

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 40

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **40** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	75	0
Transitional Housing Beds	0	8
Permanent Housing Beds	0	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Housing Resources and Homeward Bound will finalize purchase of eight units and complete a building rehabilitation and begin placing eight veterans into long-term, permanent housing by Spring 2005.
Transitional living facility	Grand Valley Catholic outreach and Homeward Bound plan to apply for funding through VA Grant and Per Diem program and expand current programs.
Dental Care	Based on current budget, we may be able to expand dental services.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 6 Non-VA staff Participants: 67%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Help managing money	2	0%	2.71	7
2	Dental care	2.17	50%	2.34	2
3	Guardianship (financial)	2.17	0%	2.76	9
4	Child care	2.2	25%	2.39	3
5	Long-term, permanent housing	2.5	50%	2.25	1
6	Legal assistance	2.5	0%	2.61	4
7	Eye care	2.67	0%	2.65	5
8	Glasses	2.67	0%	2.67	6
9	Help getting needed documents or identification	2.67	0%	3.16	23
10	Welfare payments	2.83	0%	2.97	16
11	Help with transportation	2.83	0%	2.82	11
12	Help with medication	3	0%	3.18	24
13	Halfway house or transitional living facility	3.17	25%	2.76	8
14	TB testing	3.17	0%	3.58	36
15	TB treatment	3.17	0%	3.45	33
16	SSI/SSD process	3.17	0%	3.02	19
17	Job training	3.17	0%	2.88	14
18	Education	3.17	0%	2.88	13
19	Detoxification from substances	3.33	0%	3.11	22
20	Services for emotional or psychiatric problems	3.33	0%	3.20	25
21	Treatment for dual diagnosis	3.33	0%	3.01	18
22	Family counseling	3.33	0%	2.85	12
23	Women's health care	3.33	0%	3.09	21
24	Discharge upgrade	3.33	0%	2.90	15
25	Treatment for substance abuse	3.5	0%	3.30	28
26	Hepatitis C testing	3.5	0%	3.41	32
27	VA disability/pension	3.5	0%	3.33	29
28	Help with finding a job or getting employment	3.5	0%	3.00	17
29	Personal hygiene (shower, haircut, etc.)	3.67	0%	3.21	26
30	Food	3.83	25%	3.56	35
31	Clothing	3.83	0%	3.40	31
32	Emergency (immediate) shelter	3.83	25%	3.04	20
33	Medical services	3.83	0%	3.55	34
34	Drop-in center or day program	3.83	0%	2.77	10
35	AIDS/HIV testing/counseling	3.83	0%	3.38	30
36	Spiritual	4.33	0%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.17	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.83	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.83	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.5	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.8	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.6	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.6	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.8	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.6	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.8	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.8	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.8	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.2	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Salt Lake City, UT - 660

VISN 19

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 703

2. Point-in-time estimate of Veterans who are Chronically Homeless: 205

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **703** (point-in-time estimate of homeless veterans in service area) **X 35%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 83%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 205** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1054	40
Transitional Housing Beds	456	108
Permanent Housing Beds	481	140

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Help with finding a job or getting employment	State of Utah's Department of Workforce veteran representative staff will continue its presence at Salt Lake City VA Regional Office where they have an office. Closer ties will be reinforced between VA Homeless Program and DVOPS located throughout the region to help veterans become aware of employment options.
Long-term, permanent housing	A new partnership, "Homeless Housing Partnership," was created in FY 04 between the Housing Authority of Salt Lake City, the Housing Authority of the County of Salt Lake and the Crusade for the Homeless to create 500 permanent housing units with supportive services within 10 years. the SLC Housing Authority plans to break ground in the Spring of 2005 -- dedicating approximately 50 units for veterans.
Treatment for Dual Diagnosis	First Step House received VA Special Needs funding for chronically mentally ill in FY 2004. They plan to conduct a Critical Time Initiative (CTI) model for 12 veterans in collaboration with VA Homeless Program.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 10 Non-VA staff Participants: 50% Homeless/Formerly Homeless: 10%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Eye care	2	0%	2.65	5
2	Glasses	2	0%	2.67	6
3	Dental care	2.25	0%	2.34	2
4	Legal assistance	2.33	0%	2.61	4
5	Child care	2.38	0%	2.39	3
6	Long-term, permanent housing	2.67	43%	2.25	1
7	Detoxification from substances	2.78	0%	3.11	22
8	Family counseling	2.78	0%	2.85	12
9	Drop-in center or day program	2.78	0%	2.77	10
10	Welfare payments	2.78	0%	2.97	16
11	Guardianship (financial)	2.78	0%	2.76	9
12	Education	2.88	0%	2.88	13
13	Discharge upgrade	2.88	0%	2.90	15
14	Personal hygiene (shower, haircut, etc.)	2.89	0%	3.21	26
15	Help with medication	2.89	14%	3.18	24
16	Help managing money	2.89	0%	2.71	7
17	Women's health care	3	0%	3.09	21
18	SSI/SSD process	3	0%	3.02	19
19	Job training	3	0%	2.88	14
20	Services for emotional or psychiatric problems	3.11	14%	3.20	25
21	Help with finding a job or getting employment	3.11	29%	3.00	17
22	Help with transportation	3.11	0%	2.82	11
23	Treatment for substance abuse	3.22	0%	3.30	28
24	Medical services	3.22	14%	3.55	34
25	VA disability/pension	3.22	14%	3.33	29
26	Help getting needed documents or identification	3.22	14%	3.16	23
27	Treatment for dual diagnosis	3.25	29%	3.01	18
28	Clothing	3.33	0%	3.40	31
29	Emergency (immediate) shelter	3.33	0%	3.04	20
30	AIDS/HIV testing/counseling	3.33	0%	3.38	30
31	Halfway house or transitional living facility	3.44	29%	2.76	8
32	TB treatment	3.44	0%	3.45	33
33	Hepatitis C testing	3.5	0%	3.41	32
34	Food	3.56	0%	3.56	35
35	TB testing	3.56	0%	3.58	36
36	Spiritual	3.63	0%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.89	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.67	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.11	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.11	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.11	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.44	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.11	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.89	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.6	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.7	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.9	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.4	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.5	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.9	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.3	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.1	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.2	1.84

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CHALENG 2004 Survey: VAMC Sheridan, WY - 666

VISN 19

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 30

2. Point-in-time estimate of Veterans who are Chronically Homeless: 7

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **30** (point-in-time estimate of homeless veterans in service area) **X 26%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 91%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 7** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	21	0
Transitional Housing Beds	20	0
Permanent Housing Beds	88	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Help with Transportation	Attempt to develop other transportation options and improve existing options through DAV transportation system, researching grant monies to purchase a van, etc.
Long-term, permanent housing	See if more permanent housing can be committed from existing providers.
VA disability/pension	Get local VA benefits counselor to present workshop at homeless shelter regarding available benefits and how to apply.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 29 Non-VA staff Participants: 86% Homeless/Formerly Homeless: 55%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.38	27%	2.25	1
2	Halfway house or transitional living facility	2.63	18%	2.76	8
3	Child care	2.68	9%	2.39	3
4	Legal assistance	2.78	9%	2.61	4
5	Welfare payments	2.8	5%	2.97	16
6	Help with transportation	2.81	23%	2.82	11
7	Discharge upgrade	2.83	0%	2.90	15
8	Drop-in center or day program	2.88	5%	2.77	10
9	Dental care	2.89	18%	2.34	2
10	Job training	2.91	9%	2.88	14
11	Help managing money	3.1	0%	2.71	7
12	Education	3.21	5%	2.88	13
13	Guardianship (financial)	3.24	0%	2.76	9
14	VA disability/pension	3.29	18%	3.33	29
15	Help getting needed documents or identification	3.3	5%	3.16	23
16	Family counseling	3.38	0%	2.85	12
17	SSI/SSD process	3.45	5%	3.02	19
18	TB treatment	3.46	5%	3.45	33
19	Spiritual	3.48	0%	3.30	27
20	Women's health care	3.52	0%	3.09	21
21	Help with finding a job or getting employment	3.59	13%	3.00	17
22	Eye care	3.67	5%	2.65	5
23	Hepatitis C testing	3.69	9%	3.41	32
24	AIDS/HIV testing/counseling	3.71	0%	3.38	30
25	Glasses	3.78	0%	2.67	6
26	Detoxification from substances	3.8	5%	3.11	22
27	Help with medication	3.96	4%	3.18	24
28	Treatment for substance abuse	4.04	0%	3.30	28
29	Services for emotional or psychiatric problems	4.07	5%	3.20	25
30	Medical services	4.07	9%	3.55	34
31	Treatment for dual diagnosis	4.08	0%	3.01	18
32	Clothing	4.11	0%	3.40	31
33	Food	4.26	0%	3.56	35
34	Personal hygiene (shower, haircut, etc.)	4.27	0%	3.21	26
35	TB testing	4.27	0%	3.58	36
36	Emergency (immediate) shelter	4.46	0%	3.04	20

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.07	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.48	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.03	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.9	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.93	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.76	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.82	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.71	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.65	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.65	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.06	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.53	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.88	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.71	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.59	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.82	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.82	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.71	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.94	1.84